WESTCARE HOSP
(CLINICS & MATERNIT

Our Ref:.....*Your Ref:*.....*Date:*.....

PATIENT REFERRAL FORM

PATIENT'S NAME: Enwerema Priscilia

Date: 20/12/2024

Age: F/Adult. Sex: .....

Company/ HMO: Pro-health.

Card NO: PH/200/104/03

Type of Health Plan: .....

Name of Referring Doctor: Dr. Obidey.

Clinical History: .....

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Diagnosis: Recurrent Boil ? cause /Pto Dm.

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Management given by referring Hospital: .....

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Indication(s) for referral: To do Glucose tolerance Test (OGTT)

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Name of Hospital referred to: AFRIGLOBAL MEDICARE.

Address of Hospital referred to: .....

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Name of Specialist referred to: .....

Thanks.